Desjardins Insurance
Life • Health • Retirement

200, rue des Commandeurs
Lévis (Québec) G6V 6R2
www.desjardinslifeinsurance.com

CRITICAL ILLNESS CLAIM FORM
Insured's statement

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

Identification of insured

Last name		Date of birth
First name	Contract number	Claimant number

General information

1. Diagnosis

2. When did symptoms of this illness first appear? YYYY - MM - DD

3. When did you first consult a physician for this illness? YYYY - MM - DD

4. Do you have a family doctor? ☐ Yes ☐ No If yes, specify:
Doctor's name: ____________________ Since when? ____________

5. In the 2 years preceding your date of diagnosis, did you consult a physician or healthcare professional or were you hospitalized for any medical reasons? ☐ Yes ☐ No If yes, please complete the table:

Name of physicians or professionals consulted	Medical reasons	Dates of consultation	Name of hospitals where you were treated	Hospitalization periods
		YYYY - MM - DD		from: YYYY - MM - DD to: YYYY - MM - DD
		YYYY - MM - DD		from: YYYY - MM - DD to: YYYY - MM - DD

6. In the 2 years preceding your date of diagnosis, did you take any medication? ☐ Yes ☐ No If yes, please complete the table:

Medical reasons	Name of medication	Periods
		from: YYYY - MM - DD to: YYYY - MM - DD
		from: YYYY - MM - DD to: YYYY - MM - DD

7. In the 2 years preceding your date of diagnosis, did you work for any employers? ☐ Yes ☐ No If yes, please complete the table:

Name and address	Employment period
	from: YYYY - MM - DD to: YYYY - MM - DD
	from: YYYY - MM - DD to: YYYY - MM - DD

8. Do you smoke cigarettes, cigarillos, cigars, a pipe, or do you use any other form of tobacco or tobacco substitute such as gum or a nicotine patch?
☐ Yes ☐ No

9. Did you ever use tobacco in any form whatsoever? ☐ Yes ☐ No If yes, when did you stop? YYYY - MM - DD

10. If you are on leave or have ceased to perform your normal activities due to this illness, please answer the following questions:
    a) When was your last full day of work, or the day you ceased to perform your normal activities? YYYY - MM - DD
    b) Did you work for at least 80 paid hours during the 4 weeks preceding the last full day of work?
    ☐ Yes ☐ No If no, please state why: ____________________
    c) Name of your employer: ____________________ Employer's telephone number: AREA CODE + NUMBER

Declaration – I declare that the information provided above is complete and true.

Signature of insured
(or representative) ____________________ Date ____________

B3E (15-05)